STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING _____ B. WING _____	C 01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS GROVE REHABILITATION CENTER	4255 MEDWELL DRIVE NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00084883. Complaint IN00084883 - Substantiated. Federal/State deficiencies related to the allegations are cited at F 279 and F 514 Survey dates: January 24 and 25, 2011 Facility number: 000173 Provider number: 155273 AIM number: 100290920 Survey team: Anne Marie Crays RN Census bed type: SNF: 9 SNF/NF: 87 Total: 96 Census payor type: Medicare: 9 Medicaid: 57 Other: 30 Total: 96 Sample: 5 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 1/26/11 by Suzanne Williams, RN	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. Cypress Grove Nursing and Rehabilitation Center desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective February 2, 2011.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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FEB - 7 2011
LONG TERM CARE DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/3/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a care plan regarding a resident's refusal of breathing treatments was developed, for 1 of 3 residents reviewed with breathing treatments, in a sample of 5. Resident B Findings include: On 1/25/11 at 11:15 A.M., the Director of Nursing provided the current facility policies on the "Plan of Care," revised October 2008. The policy included: "...Complete the Plan of Care by including the following:...b. Date the resident need was identified. c. Identified need. d. Realistic, measurable resident goal. e. Projected date the goal will be met. f. Specific individualized	F 279	It is the policy of Cypress Grove to develop a plan of care that includes measurable objectives and timetables to meet residents' needs. On January 24, 2011, resident B's care plan was updated to reflect refusal of nebulizer treatments as well as resident's current condition. A 100% review of all care plans, including but not limited to refusal of care was conducted on February 1, 2011 with plans of care updated as needed. Professional Staff re-education was completed on February 1, 2011 related to refusal of care documentation. On February 1, 2011 Director of Social Services was re-educated regarding care planning of refusal of care. DON/Designee will review 24 hour shift reports daily for 14 days, then five times/week thereafter to ensure identification of any occurrences that require an updated care plan intervention. Identified residents will be brought to Daily Clinical Review meeting and care plans updated by the interdisciplinary team.	

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F 279	Continued From page 2 interventions...Discipline responsible for providing the intervention...." The clinical record of Resident B was reviewed on 1/24/11 at 10:00 A.M. The resident was admitted to the facility on 12/18/10 with diagnoses including, but not limited to, Shortness of Breath, Acute Respiratory Failure, and Chronic Obstructive Pulmonary Disease. A Nursing Comprehensive Admission Assessment, dated 12/18/10, indicated the resident was alert, but not oriented to person, place, or time. A Physician's order, dated 12/18/10, indicated, "Duoneb UD [a respiratory medication] TID [three times daily] per neb [nebulizer machine]." A Medication Administration Record [MAR], dated 12/10, indicated the resident was scheduled to receive the nebulizer treatments at 6:00 A.M., 2:00 P.M., and 8:00 P.M. The MAR indicated the resident refused the nebulizer treatments at 6:00 A.M. 8 times, the 2:00 P.M. treatment 9 times, and the 8:00 P.M. treatment 7 times. The 2:00 P.M. treatment on 12/20 and the 8:00 P.M. treatment on 12/26 were blank. A reason for the refusal of the treatments was not documented on the MAR. Nursing Progress Notes included the following notations: 12/20/10 at 7:30 P.M.: "...cooperative except refused breathing tx [treatment]...." 12/21/10 at 8:45 P.M.: "...refused breathing tx...."	F 279	Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in progressive disciplinary action per facility policy. Findings will be forwarded to the Quality Assurance Committee monthly for review to ensure continued compliance.	

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F 279	Continued From page 3 12/22/10 at 6:00 P.M.: "...refusing breathing tx tonight...." 12/23/10 at 8:30 P.M.: "...refusing breathing tx's and breath sound auscultation. Pt. [patient] refusing VS [vital signs]...." 12/23/10 at 6:30 A.M.: "...Refused neb tx...becomes extremely SOB [short of breath] on exertion." 12/24/10 at 7:00 P.M.: "Pt. uncooperative, refusing meds, breathing tx, VS, treatments...." On 1/24/11 at 11:30 A.M., the Director of Nursing [DON] indicated Social Services would usually write a care plan if a resident refuses treatments. On 1/24/11 at 12:30 P.M., during an interview with the Social Services Director [SSD], she indicated she was not aware the resident had been refusing the breathing treatments. The SSD indicated she would be the person responsible for developing a care plan if a resident resisted care or treatments, and would then meet with the family about the resident's refusal. This federal tag relates to Complaint IN00084883.	F 279		
F 514 SS=D	3.1-35(a) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		

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F 514	Continued From page 4 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation was complete and accurate in that the reason for refusals of breathing treatments was not documented; physician notification of the refusal was not documented; documentation on the medication record of a discontinued order was not accurate; and documentation of nebulizer treatments being refused or given was lacking, for 1 of 3 residents reviewed for complete documentation, in a sample of 5. Resident B Findings include: On 1/24/11 at 11:45 A.M., the Director of Nursing provided the current facility policy on "Documentation," dated January 2004. The policy included: "...Documentation is designed to demonstrate the clinical picture of the resident and to ensure the appropriate information is available to all interdisciplinary team members regarding treatment interventions and responses...Document all calls to the physician and the resident's legal representative with actual, names, dates and times...Make all entries into the medical record as soon as possible after an observation, assessment, or intervention occurs...."	F 514	It is the policy of Cypress Grove to provide documentation that medication is omitted/refused. Resident B has had no further incidents of refusal of nebulizer treatments. Resident B's plan of care has been updated to reflect resident's current status. A one time 100% review of all residents that have breathing treatments was conducted on February 1, 2011 by nursing administration. No other residents were identified as refusing nebulizer treatments. The licensed nurses are required to document on the 24 hour shift report any refusals of care. The DON or Designee will review the 24 hour shift report daily X 14 days and 5 times weekly thereafter to identify any resident with refusal of care in the last 24 hours. Identified residents will be added to the Daily Clinical Review list for review by the interdisciplinary team. Review will include, but not be limited to : nurses' notes, medication administration records, respiratory flow records and physician notification as condition warrants to ensure appropriate documentation.	

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F 514	Continued From page 5 On 1/24/11 at 12:00 P.M., the Director of Nursing provided the current facility policy on "Drug Omission/Refusal," dated July 2010. The policy included: "...Document a medication omission/refusal on the Medication Administration Record (MAR). Circle your initials in the appropriate block on the MAR to indicated omitted/refused dose. Provide reason for omission/refusal in the Nursing Progress Notes or on the back of the MAR...Assess resident after medication refusal and notify physician if clinical condition warrants notification. Notify physician/family/responsible party of changes in condition related to medication regimen...Document physician and family/responsible party notification." The clinical record of Resident B was reviewed on 1/24/11 at 10:00 A.M. The resident was admitted to the facility on 12/18/10 with diagnoses including, but not limited to, Shortness of Breath, Acute Respiratory Failure, and Chronic Obstructive Pulmonary Disease. A Nursing Comprehensive Admission Assessment, dated 12/18/10, indicated the resident was alert, but not oriented to person, place, or time. A Physician's order, dated 12/18/10, indicated, "Duoneb UD [a respiratory medication] TID [three times daily] per neb [nebulizer machine]." A Medication Administration Record [MAR], dated 12/10, indicated the resident was scheduled to receive the nebulizer treatments at 6:00 A.M., 2:00 P.M., and 8:00 P.M. The MAR indicated the resident refused the nebulizer treatments at 6:00	F 514	DON/Designee will review the respiratory flow records of residents receiving routine nebulizer treatments. Review will consist of refusal of care and appropriate documentation of refusal of care. Review will be conducted daily X 14 days and 5 times weekly thereafter. Re-education related to documentation of refusal of care was completed on February 1, 2011 with all licensed nurses. This information will also be included in new-hire orientation of all licensed nurses. Identified non-compliance will result in 1:1 re-education with repeat non-compliance resulting in progressive disciplinary action per facility policy. Findings will be forwarded to the Quality Assurance Committee monthly for review to ensure continued compliance.	

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F 514	Continued From page 6 A.M. 8 times, the 2:00 P.M. treatment 9 times, and the 8:00 P.M. treatment 7 times. The 2:00 P.M. treatment on 12/20 and the 8:00 P.M. treatment on 12/26 were blank. A reason for the refusal of the treatments was not documented on the MAR. A Physician's order, dated 12/27/10, indicated, "D/C [discontinue] routine neb." The MAR did not reflect the routine nebulizer treatments had been discontinued on 12/27/10. The MAR contained entries that the nebulizer treatments were refused, except for the 6:00 A.M. treatment on 12/31/10. Nursing Progress Notes included the following notations: 12/20/10 at 7:30 P.M.: "...cooperative except refused breathing tx [treatment]...." 12/21/10 at 8:45 P.M.: "...refused breathing tx...." 12/22/10 at 6:00 P.M.: "...refusing breathing tx tonight...." 12/23/10 at 8:30 P.M.: "...refusing breathing tx's and breath sound auscultation. Pt. [patient] refusing VS [vital signs]...." 12/23/10 at 6:30 A.M.: "...Refused neb tx...becomes extremely SOB [short of breath] on exertion." 12/24/10 at 7:00 P.M.: "Pt. uncooperative, refusing meds, breathing tx, VS, treatments...." Documentation that the physician and/or family was notified of the resident's refusal of the	F 514		

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F 514	Continued From page 7 breathing treatments was not observed in the clinical record until 12/30/10. A Nursing Progress Note, dated 12/30/10 at 8:00 P.M., indicated, "Res.[resident] refused neb tx...2230 [10:30 P.M.]...was immediately bombarded [with] questions concerning...why he was refusing meds/tx...Sister stated the staff is to call her if res refuses anything...." A Nursing Progress Note, dated 1/4/11 at 12:40 P.M., indicated, "[Name of physician] here to see res. [No] n.o. [new orders] rec'd...." On 1/24/11 at 11:30 A.M., LPN # 1 indicated the resident's physician did write new orders on 1/4/11 when he visited, which included, "Albuterol UD...Q 4 [every 4 hours] PRN [as needed]." At that time, the Director of Nursing [DON] indicated the physician was aware the resident was refusing the nebulizer treatments, and that is why he ordered the routine treatments to be discontinued on 12/27/10. The DON indicated the nursing staff should have charted that in the progress notes. The DON indicated the family was aware on 12/30/10. The resident was admitted to the hospital on 1/17/11 and returned to the facility on 1/22/11. Nursing Progress Notes, dated 1/22/11 at 9:30 A.M., indicated, "Received Res from [hospital]...." A Physician's order, dated 1/22/11, indicated, "Duo-neb...by neb q 4 hours." A Medication Administration Record, dated January 2011, indicated the resident was to receive nebulizer treatments at 1:00 A.M., 4:00 A.M., 8:00 A.M., 12:00 P.M., 4:00 P.M., and 8:00	F 514		

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F 514	Continued From page 8 P.M. Documentation was lacking that the resident received a treatment on 1/24 at 1:00 A.M., 1/24 at 4:00 A.M., 1/22 at 4:00 P.M., and 1/23 at 8:00 P.M. On 1/24/11 at 11:30 A.M., the Assistant Director of Nursing indicated she had calls out to the staff working at those times, to determine if the resident had refused the treatments or had received them. This federal tag relates to Complaint IN00084883. 3.1-50(a)(1) 3.1-50(a)(2)	F 514		

On 2/1/2011 social worker, Rebecca Gansam, was educated over the policy regarding plan of care updates including but not limited to refusal of care. On 2/2/2011 Deb Ordner, Program Director, was presented the same education.

Tracey Howard RN/DON
Cypress Grove Rehabilitation Center
Newburgh, IN

FOR DESK REVIEW
CYPRESS GROVE
NEWBURGH, IN

2/1/11

On Tuesday 2/1/11, I educated our RNs and LPNs regarding proper reporting and documentation of ommitted/refused treatments, medications and all other care. The nursing staff was advised that a medication ommission/refusal is to be documented on the Medication Administration Record (MAR) by placing their initials in the appropriate block on the MAR and circling them to indicate the missed dose. A reason for the ommission/refusal must be provided either on the back of the MAR or in a Nursing Progress Note. Refused treatments must be documented with the nurse's circled initials in the appropriate box on the Treatment Administration Record (TAR) and in the Nurse's Progress Notes. The resident must be assessed following the refusal of medication or treatment and their physician and responsible party/family member immediately notified if there is a change in condition related to the altered medication/treatment regimen. All refusal of care must be documented at the time of refusal. All refusals of care, including hygiene care, must be placed on the 24 hour shift reports for further review by the IDT. All MARs and TARs are audited for refused medications/treatments that have not been identified.

Amanda Bateman, RN, ETD

FOR DESK REVIEW

CYPRESS GROVE

NEWBURGH, IN

DOCUMENTATION/CAREPLAN AUDIT

DATE:_____ AUDITOR:_____

Name	Time of Treatment	√ if tx administered or R if refused	Appropriate documentation if refused	Social Services aware of refusal	Plan of Care updated

FOR DESK REVIEW

CYPRESS GROVE

NEWBURGH, IN